CONFIDENTIAL **CONFIDENTIAL**

TEXAS DEPARTMENT OF HEALTH
General Sanitation Department
1100 West 49th Street
Austin. TX 78756

CAMPER INJURY, ILLNESS OR, DEATH REPORT FORM

All Applicable Questions Must Be Answered
Please Print or Type

CHECK THIS BOX IF THIS IS A CHANGE TO A PREVIOUSLY SUBMITTED REPORT 9

Note: This report must be submitted within 10 days of incident.

1. Camp Id Number (See License, it is second number upper right hand corner)	2. Camp Name (As it appears on License)	3. Today's Date _____ _____ _____ Month Day Year

4. Camper's Name _____ _____
First Last

5. Parent or Guardian _____ _____ Phone (_____)_____
First Last

6. Campers Home Address _____

City _____ State _____ Zip _____

7. Age	8. Sex	9. Date of Birth	10. Date of Occurrence
	Male 9 Female 9	_____ _____ _____ Month Day Year	_____ _____ _____ Month Day Year

11. Briefly Describe the Accident and Subsequent Injury, Illness, or Death

12. Is this a report of an: 9 a. INJURY 9 b. ILLNESS 9 c. DEATH.

INJURIES - SECTION A.

13. Location of the Incident.

- ☐ a. Sleeping/Living Quarters
- ☐ b. Kitchen/Dining Area
- ☐ c. Shower/Toilet
- ☐ d. Other Building
- ☐ e. Arts or Crafts Area
- ☐ f. Playground Area
- ☐ g. Trail or Nature Area
- ☐ h. Archery Area
- ☐ i. Riflery Area
- ☐ j. Swimming Area
- ☐ k. Boating Area
- ☐ l. Horseback Area
- ☐ m. Sport or Recreational Field or Court
- ☐ n. Campfire/Cookout Area
- ☐ o. Road/Highway
- ☐ p. General Campgrounds
- ☐ q. Bunks
- ☐ r. Primitive/Outpost Camp
- ☐ s. Field Trip
- ☐ t. Automobile
- ☐ u. Other (Specify)

_____

14. What Type of Event Caused the Injury:

- ☐ a. Fall from Ground Level (example Stumble)
- ☐ b. Fall from Height
- ☐ c. Collision with Person
- ☐ d. Collision with Object
- ☐ e. Struck by Another Person
- ☐ f. Struck by Missile
- ☐ g. Drowning or Near Drowning
- ☐ h. Bite or Wound Inflicted by Animal
- ☐ i. Bite or Wound Inflicted by a Person
- ☐ j. Contact with Excessive Heat or Flame
- ☐ k. Using a Tool (Including a Cutting Instrument)
- ☐ l. Contact with Sharp Object Other than a Tool
- ☐ m. Other (Specify)

_____

15. What Activities Were Involved With the Accident

- ☐ a. Archery
- ☐ b. Arts / Crafts
- ☐ c. Baseball
- ☐ d. Basketball
- ☐ e. Boating
- ☐ f. Canoeing
- ☐ g. Fighting
- ☐ h. Fishing
- ☐ i. Food Preparation
- ☐ j. Football
- ☐ k. Free Play (not an organized activity)
- ☐ l. Hiking
- ☐ m. Hockey
- ☐ n. Horseback Riding
- ☐ o. Riflery
- ☐ p. Rock Climbing
- ☐ q. Ropes Course
- ☐ r. Soccer
- ☐ s. Swimming
- ☐ t. Tennis
- ☐ u. Tetherball
- ☐ v. Volleyball
- ☐ w. Walking / Running
- ☐ x. Water Skiing
- ☐ y. Waterslide
- ☐ z. Other (Specify)

INJURIES - SECTION A. - continued

16. Injury Data (Check One Box for Each Body Part Injured)

	a. Head/Neck	b. Eye	c. Upper Limb	d. Lower Limb	e. Torso	f. Other / Unknown
a. Bruise	9	9	9	9	9	9
b Burn	9	9	9	9	9	9
c. Fracture	9	9	9	9	9	9
d. Cut	9	9	9	9	9	9
e. Puncture	9	9	9	9	9	9
f. Dislocation	9	9	9	9	9	9
g. Sprain	9	9	9	9	9	9
h. Other / Unknown	9	9	9	9	9	9

ILLNESS - SECTION B.

17. Diagnosis:

A. INFECTIONS OR INFLAMMATORY DISEASE

9 a. Dental (toothache, gum abscess, etc.)
9 b. Eye Infection
9 c. Gastroenteritis (diarrhea, vomiting)
9 d. Respiratory Infection
9 e. Sore Throat
9 f. Earache or Ear Infection
9 g. Appendicitis
9 h. Other (specify)

_____

B. ALLERGIC DISEASE (pollen, molds, weeds, food, etc.)

9 a. Insect Bite
9 b. Poison Ivy
9 c. Medication Reaction
9 d. Other (specify)

_____

C. TOXIC DISEASE (insect bites, poisoning, drug use, etc.)

9 a. Scorpion Toxin
9 b. Spider Toxin
9 c. Snake Toxin
9 d. Medication Overdose
9 e. Other (specify)

_____

D. OTHER CONDITIONS (not listed in A., B. or C.)

9 a. Asthma
9 b. Chronic Disease (specify) _____
9 c. Dehydration
9 d. Fainting
9 e. Fever
9 f. Headache
9 g. Homesick
9 h. Skin Rash
9 i. Stomach Ache
9 j. Other (specify) _____

ILLNESS/INJURY – GENERAL/RESULTS - SECTION C.

18. What treatment was given?

9 a. No Treatment
9 b. Antiseptic / Antibiotic
9 c. Anti-Inflammatory / Analgesic
9 d. Supportive Bed (bed rest, physiotherapy)
9 e. Gastrointestinal (antacid, laxative)
9 f. Antihistamine/Decongestant
9 g. Psychotropic (tranquilizers, etc.)
9 h. Other (specify)

_____

19. Where was treatment given?

9 a. No Treatment Given
9 b. Treated In Camp Infirmary Or First Aid Station
9 c. Treated In Hospital Emergency Room
9 d. Clinic Or Physician's Office
9 e. Admitted To Hospital
9 f. Other (specify)

_____

20. Who Made the Diagnosis?

9 a. Physician
9 b. Nurse
9 c. EMT
9 d. Other (specify)

21. Disposition:

9 a. Complete Recovery
9 b. Temporary Disability
9 c. Permanent Disability
9 d. Fatal
9 e. Unknown

22. Was the Camper Sent Home as a Result of This Injury or Illness?

9 a. Yes 9 b. No

23. Did the Camper Have Positive Lab Test(s)?

9 a. Yes 9 b. No

(specify)

Completed By (Please Print or Type): _____